RIDGE MEADOWS MATERNITY CLINIC

Please complete form & return to reception with your Care Card

Today's Date:

Last Name:	First Name:
Maiden Name:	
Date of Birth: _____ Day Month Year	
Primary Phone #:	Other Phone #:
Email Address:	
Language Preferred:	Ethnic Origin:
Occupation:	Hours worked/day:
Highest Level of Schooling Completed:	
Partner's Name (last, first):	
Partner's Age:	Partner's Ethnic Origin:
Partner's Work:	

Do you have a Family Doctor?	Yes	No
Family Doctor's Name:		City:

Pre-pregnancy Height (cm): Pre-pregnancy weight (kg):
Allergies:_____ _____
Medications:_____ _____

First Day of Last Period: _____-_____-_____ Day Month Year
Was your cycle regular? Yes No
How often was your cycle? _____ days
How many days did your cycle last? _____ days
What birth control were you using?
When did you stop using birth control?

Medical History

Name: _____

	NO	If YES, please describe:
Have you ever had ANY kind of surgery?		
Have you ever been 'put to sleep'? (dental work, broken bones, etc) Did you have any negative effects?		
Have you ever had a uterine/cx procedure? Abnormal pap result?		
Have you ever had any kind of breathing or heart problems?		
Have you ever had a sexually transmitted infection? (herpes, chlamydia, etc)		
Have you ever had chicken pox?		
Have you ever had any problems with bleeding or clotting?		
Do you have or have you ever had a problem with high blood pressure?		
Do you have any kind of liver, stomach or bowel problems?		
Do you have any chronic bladder or kidney issues?		
Do you have any kind hormone issues? (diabetes, thyroid, etc)		
Do you have a history of neurological problems? (seizures, concussions, etc)		
Do you have a history of mental illness or mood disorder? (depression, anxiety, bipolar, postpartum depression, etc)		
Do you have any other medical issues that we have not covered?		

Family History

Do you have a **family history** of:	NO	If YES, who?	If YES, please describe:
Heart disease?			
High blood pressure?			
Diabetes?			
Depression or psychiatric illness?			
Alcohol or drug abuse?			
Bleeding or clotting?			
Inherited diseases? (cleft palate, heart disease, babies born with birth defects)			
Ethnic diseases? (Taysachs, Sickle, etc)			
Do you have any other family history you need/want to share?			

Have you been pregnant before: No [ ] Yes [ ] – please continue completing form

Date **First Pregnancy** ended: d/m/y _____/_____/_____/

Termination [ ] Location: _____

Miscarriage [ ] duration of pregnancy in weeks: _____ D&C [Y] [N]

Live Birth [ ] Place of birth: _____ Duration of pregnancy (weeks) _____

Hours in labour: ____ Csection [ ] Vaginal [ ] Comments:

_____

Child's gender: _____ Birth Weight _____ Current health: _____

Date **Second Pregnancy** ended: d/m/y _____/_____/_____/

Termination [ ] Location: _____

Miscarriage [ ] duration of pregnancy in weeks: _____ D&C [Y] [N]

Live Birth [ ] Place of birth: _____ Duration of pregnancy (weeks) _____

Hours in labour: ____ Csection [ ] Vaginal [ ] Comments:

_____

Child's gender: _____ Birth Weight _____ Current health: _____

Date **Third Pregnancy** ended: d/m/y _____/_____/_____/

Termination [ ] Location: _____

Miscarriage [ ] duration of pregnancy in weeks: _____ D&C [Y] [N]

Live Birth [ ] Place of birth: _____ Duration of pregnancy (weeks) _____

Hours in labour: ____ Csection [ ] Vaginal [ ] Comments:

_____

Child's gender: _____ Birth Weight _____ Current health: _____

Date **Fourth Pregnancy** ended: d/m/y _____/_____/_____/

Termination [ ] Location: _____

Miscarriage [ ] duration of pregnancy in weeks: _____ D&C [Y] [N]

Live Birth [ ] Place of birth: _____ Duration of pregnancy (weeks) _____

Hours in labour: ____ Csection [ ] Vaginal [ ] Comments:

_____

Child's gender: _____ Birth Weight _____ Current health: _____

Lifestyle/Social Information

Name: _____

We would like to collect some information from you that may help us to provide you with the best prenatal care, and connect you with additional resources during your pregnancy if needed.

Are you eating a balanced healthy diet? Yes No
Are you taking folic acid? Yes No Are you taking prenatal vitamins? Yes No
Do you smoke? Yes No If yes, how many per day? If you have quit, when approximately:
Are you taking any over the counter medications? Yes No If yes, please list:
Are you taking any prescription medications? Yes No If yes, please list:
Are you using any substances? Yes No If yes, please circle: Heroin Cocaine Marijuana Methadone Crystal Meth Other:
Do you have a safe, stable place to live?
Do you have the financial means to buy groceries, prenatal vitamins, etc during your pregnancy? Yes No
Do you have any concerns about providing financially for your baby? (housing, diapers, etc) Yes No
Do you have people in your life to support you through your pregnancy and once your baby is born? Yes No If yes, please list:
Are you experiencing (or are you concerned about) violence or abuse of any kind? Yes No
Do you currently have a social worker, parole/probation officer, mental health counselor, addictions counselor? If yes, please describe:
Are you trying to get connected with any of the above service providers? Yes No If yes, please explain:

Best for a healthy future
BEGINNINGS
• A Public Health Program •

fraserhealth

PRENATAL REGISTRATION FORM
(Please Print)

Thank you for registering for the Fraser Health – Best Beginnings Program.
A public health nurse will review the information you provide. This information becomes part of your confidential medical record.
Some women will receive a call from the public health nurse to connect them with helpful resources and supports.
All women will receive a pregnancy information package.

YOUR NAME AND CONTACT INFORMATION (PLEASE PRINT CLEARLY – THANK YOU)

Today's Date year/month/day			Care Card Number	
Last Name		First Name		
Street Address		City		Postal Code
Phone Numbers	Home:	Work:		Cell:
Which phone is best to reach you at? ☐ Home ☐ Work ☐ Cell			Is it okay to leave a message on your phone?	☐ Yes ☐ No
If you do not have a phone how can we reach you?				
When is the best time to call? ☐ Anytime ☐ Morning ☐ Afternoon ☐ Not available by phone during the day				

YOUR HEALTH CARE TEAM

Name of Doctor or Midwife	City		Phone # (optional)
Name of hospital where you plan to deliver your baby			
How many months pregnant were you at your first prenatal doctor or midwife visit?	☐ 1-3 months	☐ 4-6 months	☐ 7-9 months
Are you attending, or do you plan to attend prenatal education classes?		☐ Yes	☐ No

Are you attending any of the pregnancy outreach or support programs listed below?		☐ Yes	☐ No	If yes, please check appropriate box below
	☐ POPS Program	☐ Best For Babies	☐ Kla-how-eya Aboriginal Centre	☐ Maxxine Wright Community Health Centre
	☐ Better Beginnings	☐ Healthy Babies	☐ Healthiest Babies Possible	☐ Other (Name or Program)

INFORMATION ABOUT YOU

Your Birth Date year/month/day		Your Age		
What is your due date? year/month/day		How many weeks pregnant are you today? _____weeks		
With this baby, will you be a first time parent?	☐ Yes	☐ No		
How long have you lived in Canada?	☐ Born in Canada	☐ Less than 5 years	☐ 5-10 years	☐ More than 10 years
Did you come to Canada as a refugee?	☐ Yes	☐ No		
Would you need an interpreter to speak with the nurse?	☐ Yes	☐ No		
If you need an interpreter, what language do you speak?	☐ Punjabi ☐ Mandarin ☐ Cantonese ☐ Chinese ☐ Korean ☐ Tagalog ☐ French ☐ Vietnamese ☐ Farsi ☐ Other (name of language)			
Do you identify as having Aboriginal heritage?	☐ Yes	☐ No		
Have you completed high school?	☐ Yes	☐ No		

Do you have someone you can talk to when you are upset or worried or just need to talk?	☐ Yes	☐ No
Do you have someone who can help you out with transportation, housing, childcare or other personal needs?	☐ Yes	☐ No
Are you finding it very difficult to live on your total household income?	☐ Yes	☐ No
Do you receive income assistance (e.g., disability, income assistance, employment insurance) or BC Medical Premium assistance?	☐ Yes	☐ No
During the past month have you often been bothered by feeling down, depressed or hopeless?	☐ Yes	☐ No
During the past month have you often been bothered by little interest or pleasure in doing things?	☐ Yes	☐ No

Please tick **ONE** of the check boxes about tobacco	☐ I have never smoked cigarettes			☐ I currently smoke cigarettes	
	☐ I quit smoking less than 1 year ago			☐ I quit smoking more than 1 year ago	
How often do people smoke around you?	☐ Daily	☐ Weekly	☐ Monthly	☐ Less than Monthly	☐ Never
Are you planning to breastfeed your baby?	☐ Yes	☐ No	☐ Not decided yet		

PUBLIC HEALTH NURSE COMPLETES SECTION BELOW

Health Unit (where client resides)

☐ Abbotsford	☐ Chilliwack	☐ Hope	☐ Mission	☐ North Delta	☐ TriCities - Coquitlam/Port Moody
☐ Agassiz	☐ Cloverdale	☐ Langley	☐ New West	☐ North Surrey	☐ South Delta
☐ Burnaby	☐ Guildford	☐ Maple Ridge	☐ Newton	☐ TriCities: Port Coquitlam	☐ White Rock

PHN Name	PHN Signature	Date: year/month/day	BB	BCHCP ☐ Yes ☐ No